

Elephant Allergy

SIR,—The method of choice in the treatment of asthma is to find the causative allergen and direct the patient to avoid it. Unfortunately this is not often achieved. This is believed to be the first recorded case of elephant allergy, and the patient was successfully treated by avoiding contact with elephants.

A 42-year-old zoo keeper who had suffered from asthma for a year was admitted to hospital with a fifth severe exacerbation. There were no other symptoms, and apart from bronchospasm there was no abnormality on general examination. He was treated initially with oral prednisolone, 40 mg. four-hourly, and ampicillin. The bronchospasm was rapidly relieved and the steroid dosage diminished without reaction seven days after commencement.

Full blood count and chest x-ray were normal. There was no family history of allergy. A careful personal history was taken to ascertain possible allergens. His job was to look after the zoo's baby elephant, which had been acquired a year previously. Since starting the job he had suffered many minor attacks of bronchospasm in addition to five major episodes. In retrospect he recalled that he had always been well on holidays and days off.

He had been an elephant keeper four years earlier. Unfortunately the animal developed dermatitis and a bad temper, and on two occasions had lifted the keeper in its trunk and struck him against the wall. The second occasion resulted in hospitalization with fractured ribs. The animal was destroyed.

On historical evidence it was probable that the patient had developed either a true allergy or a "psychic" allergy as a result of his traumatic experience, producing a conditioned fear of elephants. He was advised to change his job. He found other employment in the zoo, and for the past six months has remained symptom-free apart from one episode of bronchospasm on the one occasion that he bedded down the elephant.

To establish whether he suffered from a true or "psychic" allergy it was decided to test for the presence of immediate-type sensitivity. Thanks to the kind co-operation of Dr. A. W. Frankland (Director of the Allergy Department, Wright-Fleming Institute, St. Mary's Hospital) we obtained an extract of elephant skin and hair containing 100,000 Noon units/ml. By the prick-test technique the patient was tested against the following: control, mixed grass pollens, mixed tree pollens, goat, cow, mixed moulds, and *Alternaria* (all Bencard preparations) as well as the elephant extract. At fifteen minutes all the tests were negative except for the elephant extract, which had produced a weal 7 mm. in diameter and a flare 30 mm. in diameter.

It is clear the patient is allergic to elephants, and he has been advised, and convinced, that his well-being depends on avoiding them in the future.—We are, etc.,

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W. O. McCORMICK.

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Measles Vaccination

SIR,—It is difficult to follow the reasoning of Dr. A. W. O. Taylor (7 December, p. 642) when he advises against measles vaccination. Dr. Taylor draws attention to evidence that subacute sclerosing panencephalitis attributable to measles virus can develop

several years after an attack of measles. He is worried about the risk of this complication occurring as a result of vaccination with live attenuated measles vaccine, and urges that vaccination programmes be discontinued, mainly for this reason.

The article¹ on which Dr. Taylor bases his argument gives particulars of three cases of subacute sclerosing panencephalitis and states clearly that all three had had measles and none had received either killed or live attenuated measles virus vaccine. Is it not, therefore, possible that they would have been protected by vaccination? Is this not another reason for avoiding attacks of measles? If this is accepted, since killed vaccines do not give prolonged immunity, the use of attenuated live vaccine is at present the best method of acquiring the necessary antibodies.

Subacute sclerosing panencephalitis is rare, and even if (for the sake of argument) attenuated live vaccine proves in future to carry as much risk of this complication as wild measles virus it is hard to see how we can lose by vaccination. In the first paragraph of his letter Dr. Taylor mentions some of the ways in which we may hope to gain.—I am, etc.,

J. TWOMEY.

Medical Officer of Health.

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Worcs.

REFERENCE

- ¹ Connolly, J. H., Allen, I. V., Hurwitz, L. J., and Millar, J. H. D., *Quart. J. Med.*, 1968, **37**, 625.

Drug Intervention in the Common Cold

SIR,—Dr. H. E. Webb's article under the heading "For Debate" (14 December, p. 684) has emphasized a process which is usually given little consideration in our day-to-day treatment of minor illness. If these ideas are applied to the common cold it may help us to avoid causing so many complications by our interventions with drugs. The number of viruses which are known to "cause a cold" are expanding every year. It is also known that many more infections by these viruses are aborted silently. Other cold episodes move on to involve sinuses, tonsils, middle ears, bronchi, and lung parenchyma. The whole of the gastrointestinal tract is also vulnerable to a number of viruses which can also cause colds. We are ignorant of many of the factors which influence host resistance. It must be a positive state, rather than a negative absence of disease. The cold is a harmless local reaction to contain and inactivate a potentially dangerous virus. Why do we deploy drugs to suppress this reaction? The pyrexial reaction is also, in my opinion, a general device to inactivate foreign protein or virus; why interfere? The results of doing so are uncertain, and often highly dangerous. Complications can be severe, and convalescence prolonged. This compares most unfavourably with the results of allowing natural host resistance to handle the initial virus invasion by using only placebo therapy. The more this is put into practice the more confident one becomes of a rapid, and uneventful, outcome when the host's built-in defence mechanisms are allowed free play.

In an epoch when humans are herding together in large numbers, where the conditions for virus spread are optimal, it is surely logical that we should study factors which enhance host resistance, and apply the prin-

ciples learned to the treatment of infants and young children in order that they have the chance to develop effective immunity. In order to create this host resistance in the rising generation we must cease to mask and to manipulate the symptoms of disease, because this mutilates the mechanisms of immunity.—I am, etc.,

Romford, Essex.

P. D. MULKERN.

Occupational Cancer of the Scrotum

SIR,—Dr. W. Jeaffreson Lloyd (28 December, p. 830) gives the impression that occupational cancer of the scrotum is a rare condition, and this view is endorsed by the statement made by Lord Hughes¹ in the House of Lords on 23 October 1968 that "during the years 1963 to 1967 inclusive 38 cases of cancer of the scrotum were notified among men in the engineering industry." But I wonder whether this condition is really so rare.

In the past year two such patients have presented at the North Middlesex Hospital and a third one was seen in 1962. All three had been employed as autosetters in local engineering factories. One of these patients had his occupation listed as a security officer, and only on direct questioning did it emerge that he had spent 30 years as an autosetter. It is easy to see how inaccurate notification could occur. Three more cases have been seen at a hospital 20 miles away within the past two years.

The postwar use of a highly penetrating oil mist for machine-tool operation may account for the recent apparent increase in occupational cancer of the scrotum and may mean that we can expect more cases to appear in the next few years.—I am, etc.,

MAURICE SUTTON.

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London N.18.

REFERENCE

- ¹ *Brit. med. J.*, 1968, **4**, 336.

SIR,—Readers are indebted to Dr. W. Jeaffreson Lloyd (28 December, p. 830) for his letter about the problems of epithelioma of the scrotum. This condition used to be common in mule spinners in the days when the cotton industry was at its peak. The late Dr. E. M. Brockbank's booklet on mule spinners' cancer¹ still seems relevant today, even though newer industries are the ones concerned now.—I am, etc.,

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A. F. ROBINSON.

REFERENCE

- ¹ Brockbank, E. M., *Mule Spinners' Cancer, Epithelioma of the Skin in Cotton Spinners*, 1941. London.

Venous Ulcers

SIR,—In the leading article on venous ulcers (14 September, p. 634) you say: "Our ignorance of the basic abnormalities and . . . our treatment is often illogical and empirical." I venture to suggest that this is so because of acceptance of views which on analysis are to say the least misleading. One of these is "incompetence," which has preoccupied the minds of medical men to the exclusion of other important factors. Another is to blame exercise for causing ulceration.